Wisconsin 2003 Collaborative Systems of Care Annual Report on Integrated Services Projects and Coordinated Services Team Initiatives for the Children Come First Advisory Committee

This report is written for the Children Come First Advisory Committee, the group statutorily responsible for monitoring the development of Integrated Services Projects in Wisconsin. This report highlights the accomplishments and challenges faced by collaborative systems of care in Wisconsin, namely the Integrated Service Projects (ISPs) and Coordinated Services Team Initiatives (CSTs).

─────────── BACKGROUND ───────────

Wisconsin's Collaborative Systems of Care go by many names: the Coordinated Services Team Initiative (CST), Wraparound, Integrated Services Projects (ISP), and "Children Come First" (CCF) are all approaches to respond to individuals and families with multiple, often serious needs in the least-restrictive setting possible. They are not specific programs or services, rather, a process based on family and community values that is unconditional in its commitment to creatively address needs. Services are developed by client-centered teams that support community-based options. Each team develops an individualized plan, which incorporates strengths of the participant and team to address needs. Participants are equal partners and have ultimate ownership of the plan.

Far fewer children in the United States in need of mental health services receive them. Wisconsin's treatment ratio reflects this national trend of under-diagnosed and under-treated children. ISPs and CSTs help respond to the estimated 18,000 children in need of mental health services. Further, it is recognized that many children with mental health needs are or will become involved in other systems of care (e.g. juvenile justice, AODA, child welfare). The vision of collaborative systems of care in Wisconsin is to respond to any individual with multiple needs in a collaborative, wraparound approach.

Wisconsin has been developing Collaborative Systems of Care since 1989. The original initiatives, ISPs, focused on supporting families with children with Severe Emotional Disabilities (SED) in their homes and communities.

In 2002, the collaborative process employed by ISPs was formally expanded with the development of CSTs. While CSTs employ the same basic wraparound process, the target group has been expanded to include children who do not necessarily have an SED diagnosis but who have multiple, complex needs, and who are involved in multiple systems of care (e.g. substance abuse, child welfare, juvenile justice, and/or mental health system(s)).

─────── CURRENT INITIATIVES SERVING ─────── CHILDREN AND FAMILIES

Wraparound Milwaukee, the State's largest collaborative system of care, was recognized in May 2003 by the Presidents Mental Health Commission as "a national model in the delivery of comprehensive and individualized care for children with mental health needs." Wraparound Milwaukee provided comprehensive services to meet the needs of 905 youth and their families in 2003.

Children Come First of Dane County, the State's second largest wraparound system-of–care, served 251 youth and their families in 2003.

Dane County's Children Come First project and Wraparound Milwaukee are managed care projects funded with a combination of Medicaid and county administered funds.

A combined six-county wraparound project called the **Northwoods Alliance for Children and Families (NACF)** serves children in rural northern Wisconsin. 2003 marks the final year of a six-year federal grant from the Center for Mental Health Services (CMHS) for NACF which helps support the project. In 2003 NACF served 107 youth and their families.

Kenosha County's Families First Project receives Mental Health Block Grant funds and Hospital Diversion Funds from the State to increase diversion of children and adolescents from hospitalization. Kenosha served a monthly average of 55 youth and their families throughout 2003. The number of children in out-of-home placements (inclusive of corrections, group homes, foster care, treatment foster care, and residential care centers)

went from an average of 261 for the first quarter of 2003, (compared to 368 for the first quarter of 2002) to 215 for the third quarter of 2003, (compared to 290 the third quarter of '02). This represents a decrease of out-of-home placements in 2003 of 18%.

Besides Kenosha County, an **additional 25 counties** have formal collaborative systems of care that receive Mental Health Block Grant (MHBG) funds (ISPs) or a combination of MHBG funds, funds from the Division of Children and Families, and Substance Abuse Grant (CSTs). In 2003, these 26 collaborative systems of care served 500 formally enrolled child and family teams and an additional 250 "informally" enrolled child and family teams. "Informal" teams refer to teams that are supported above and beyond the scope of the grant. Because grant funds are limited in the number of teams they can support; counties successful in system change find themselves serving many family teams (i.e. "informal" teams) utilizing resources other than grant funds.

─────── **ACCOMPLISHMENTS IN 2003** ───────

Expansion

A formal expansion of collaborative systems of care in Wisconsin was implemented in 2002 with the Coordinated Services Team (CST) Initiative. While CSTs share the same principles as ISPs (family-centered, strength-based, unconditional care, etc.), efforts have been made to not only expand the target group, but to also increase expectations for partners involved in formal collaborative systems. Counties receiving funding to develop such systems must work toward "system change" in the manner services and supports are delivered to all children and families who require coordination and collaboration. System partners include the child welfare, mental health, and substance abuse systems, as well as collaboration with other systems such as juvenile justice, education, W-2, and domestic violence service providers.

Six counties were selected to receive three to five years of system-change funding through the development of CSTs in 2002: Calumet, Green Lake, Iron, Jefferson, Manitowoc, and Waupaca. Four counties were added in 2003: Bayfield, Marquette, Portage, and Sauk. All ten sites have

established working Coordinating Committees, Interagency Agreements (document outlining values and expectations for system partners), and have received training on the core values of collaborative systems of care and on the development of coordinated plans of care.

Training and Technical Assistance

Staff support and funding assistance were provided for:
- The Annual Crisis Conference, attended by approximately 500 people. Scholarships were offered for consumers.
- The Children Come First Conference, which drew over 300 participants, including many parents, children and other family members.
- The Family Based Services Association Conference and Networking Neurons, a brain development conference.
- Statewide Project Directors' tri-annual trainings. Attendance included staff from all CSTs and ISPs, several private agencies, and parents.
  Training day events included:
  - "Advanced Issues in System of Care and the Wraparound Process" presentation by John VanDenBerg, nationally recognized wraparound trainer
  - "Asperger's Syndrome: Assessment and Intervention Approaches" presentation by Andrew Paulson, PhD
  - "Crisis Stabilization for Kids" presented by Jeff Lewis
  - "Bipolar Disorder in Children" presented by Ken Herrmann, MD
- Funding was also allocated to support locally/regionally tailored training and consultation. A variety of topics were addressed in county-specific and regional trainings held in several counties across Wisconsin. Some topics included: Systems Change; Team-Building & Service Coordination; Role of the Coordinating Committee; Billing for Medicaid Targeted Case Management; and training on the use of the Child and Adolescent Functional Assessment Scale (CAFAS).

Outcomes & Feedback

Quarterly Reports

Counties with operational ISPs and CSTs are required to provide outcome data for each child at time of enrollment, and quarterly thereafter to the Bureau of Mental Health and Substance Abuse Services. One of the tools used to collect such data is the Child and Adolescent Functional Assessment Scale (CAFAS).

The CAFAS is a nationally-recognized instrument used to provide a "behavioral snapshot" of a youth's functioning across eight subscales: role performance at school, role performance at home, role performance in the community, behavior toward others, moods & emotions, self-harmful behaviors, substance use, and thinking. Changes over time in individual subscale scores as well as changes in total scores serve as indicators to teams of where a child has improved and in what areas collaborative planning still needs to occur.

Specific outcomes in overall functioning, functioning at school, and functioning in the community (juvenile justice outcomes) are detailed in Appendix II.

The Family Satisfaction Survey

Each year, the Bureau of Mental Health and Substance Abuse Services in collaboration with Wisconsin Family Ties distributes a Family Satisfaction Survey to all families involved in ISPs and CSTs across Wisconsin. In 2003, 151 surveys were returned, yielding a 47.6% response rate.

The survey asks families to rate 12 statements regarding satisfaction with their team experience using the following scale: strongly agree, agree, undecided, disagree, and strongly disagree. There is also an "N/A" option. 86% of all responses were either "Strongly Agree" or "Agree", indicating high overall family satisfaction with the process.

The most favorably rated statement was "The team schedules services and meetings at times that are convenient to me and my family" (94% responded "Strongly Agree" or "Agree"), indicating a great strength of team members to respect and consider the schedule of parents when planning meetings.

The least favorably rated statement was, "If my child is 14 or older, the team has a plan to insure he/she can get needed services when 18". Although a large percentage (61.6%) either did not respond or responded "N/A", of those who did respond (N=58), only 24% "Agreed" or "Strongly Agreed", where 15% "Disagreed" or "Strongly Disagreed", and 33% were "Undecided". These results suggest a need to emphasize and improve teams' attention on youth transition issues.

Please refer to Appendix III for a summary of responses to the individual statements in the Family Satisfaction Survey.

The Wisconsin Collaborative Systems of Care System Change Update

Counties with ISPs and CSTs are asked to fill out an annual survey including information on the personnel structure of their project, enrollment information, and "system impact" of their collaborative efforts.

This report reflects the far-reaching effects of collaborative team efforts across Wisconsin. Total youth and family teams in 2003, as reported by 26 counties, was 750, an increase over the 668 teams served in 2002 and 666 in 2001.

Counties also reported on the number of family members other than the identified youth who received support and services they may not have received if the family had not been involved in the collaborative team process. In 2003, there were 1,767 additional people served. This compares to 1,363 in 2002 and 1,503 in 2001.

Given the data collected, the total number of youth and family members served through the collaborative team process in 2003 was 2,517 individuals.

Finally, counties were asked to report on how their collaborative initiative (ISP/CST) positively or negatively impacted other parts of the child and family service delivery system in their county. Respondents shared an overwhelming number of comments on positive outcomes in the areas of increased cross-system collaboration, financial savings, impacts on families, and the positive impact on other systems such as the juvenile justice and child welfare systems, schools, and crisis

response. The survey yielded only one "negative impact" stated: "…a waiting list and the need to expand the program."

For more information on enrollment, and a summary of counties' comments relating to impacts, see Appendix IV.

The Coordinated Services Team Initiative Annual System Change Report 2003

Upon receiving funding, each of the 10 sites were asked to complete a "Goals and Expected Outcomes Checklist". The initial completion of this tool serves as a baseline for each county. Counties are asked to evaluate their current system in three areas (system outcomes supporting CST; process outcomes supporting CST; and, family-specific outcomes) by rating themselves on several indicators pertaining to each of the three areas. The rating scale ranged from 1 – 5, with 1 = "Ready to begin" and 5 = "Fully developed/operational".

Results show shared areas of strength and need across counties.

For the "System Outcomes" category, "Family involvement on Coordinating Committees and family teams" is an area of strength among the sites. Providing services that are culturally competent, strength-based and family-centered services are also areas of strength. Areas reported consistently lower by sites, indicating areas needing additional technical assistance, include: a reinvestment of realized savings from substitute care budgets in community-based CST processes; planning for future sustainability; and provider satisfaction in the process.

Of the three general outcome areas rated (System Outcomes, Process Outcomes, and Family-Specific Outcomes), the "Process Outcomes" area was rated lowest by sites. Specifically, counties rated indicators related to advocacy and transition planning as areas of need.

To view the complete report, see Appendix V.

The Eight Key Components of Collaborative Systems of Care Self-Report Summary for 2003

Counties with existing ISP and CST initiatives were asked to respond to how well they are meeting the

eight key process and outcome areas that are important to maintaining a successful collaborative systems of care. A self-report was completed by 19 counties with information from Coordinating Committees, project and service coordinators, and family members.

The Eight Key Components of Integrated Services are paraphrased below:
- Parents are full partners
- Coordinating Committee has agreed upon the core values and guiding principles
- Family teams create and implement individualized Plans of Care for families
- Significant collaborative funding is available
- Advocacy is provided for each family
- Ongoing training is provided
- Functional goals are monitored and measured
- Adolescents are ensured a planned transition to adult life

Notably, there were several indicators that received ratings of "Always" (4 on a scale of 1 – 4) and "Yes" (given the choice of "Yes" or "No") 100% of the time across counties. These indicators (areas of apparent strength Statewide) include:
- Parents are present at team meetings. Children are present whenever possible and appropriate
- Parents are on Coordinating Committee and appropriate subcommittees
- Coordinating Committee meets at least quarterly
- Family advocacy information and options are provided
- Advocates may participate as team members as requested by family
- Generally, outcomes show:
  - A decrease in police contact/recidivism rates
  - Maintenance or decrease in level of restrictiveness of living
  - Improvement in grades
  - Improvement in attendance
  - Decrease in problem behaviors

Some indicators rated significantly lower by counties include:
- The Coordinating Committee reviews interagency agreements at least every 3 years (83% responded "Yes", 17% responded "No")

- Conflict resolution polices are clearly written and reviewed at least annually. (82% responded "Yes", 18% responded "No")
- Child and Family teams access informal community resources (39% responded "Always", 50% responded "Often", and 11% responded "Seldom")

To view a more detailed summary of results, see Appendix VI.

The Children and Youth Committee of the Wisconsin Council on Mental Health, staffed by Bureau of Mental Health & Substance Abuse Services staff, continues to meet and make recommendations to the Wisconsin Council on Mental Health on prioritized issues that effect collaborative efforts in Wisconsin including: respite care, insurance parity, crisis care, and family education/support/recreation.

The Data Infrastructure Grant from the Center for Mental Health Services (CMHS) has helped in the creation of a single data warehouse for combined public mental health data such as the Human Service Reporting System and Medicaid data. The linking of these two data sets should provide comprehensive data that has not been available for analysis in the past. The grant has also been used to fund the annual statewide Consumer Satisfaction Survey.

————— CHALLENGES FOR THE FUTURE —————

Expansion

Despite progress made in 2003 toward making collaborative systems of care available to all families in Wisconsin that need them, there remains a lot more to do. Given the proven effectiveness of the wraparound process in both provision of services and cost savings, the Bureau of Mental Health and Substance Abuse Services would like to see this approach to delivering services and developing supports spread throughout Wisconsin, encompass more service systems, and reach broader target populations.

Given the State's continuing budget and the funding issues, it is difficult for many counties to maintain,

let alone expand, high quality, individualized services.

A continuing goal for the future is to expand partnership and support, including financial support, from additional systems of care. Where the CST initiative has begun this process, the goal is to expand the collaborative process to include anyone (adult, child, family) who needs it, regardless of their point of entry in the system of care.

Advocacy

Wisconsin Family Ties, the primary information, referral, and support agency for families with children with emotional disorders in Wisconsin, has suffered staff and service cutbacks due to the loss of some of its funding. This coincides with increased demand for the important services they provide. The network of trained family advocates statewide needs to be expanded and strengthened. Many rural areas are primarily served by telephone support as opposed to the preferred personal in-community support.

Transition

As evidenced in results of the 2003 Family Satisfaction Survey and 2003 CST Annual System Change Report, there continues to be gaps in support to youth transitioning out of the adolescent system who are in need of continued services in the adult system. This support needs to be incorporated into each county's existing services, and should be available to any "graduate" or current enrollee of a collaborative system of care.

Data Collection and Reporting

The process of data collection and reporting needs improvement. The current reality is that staff of collaborative systems of care initiatives and their partners are required to report data to sometimes several different sources – none of which are integrated. As a result, the task of analyzing, comparing, and meaningfully reporting data from collaborative systems of care is very encumbering. The hope is that the development of a single data warehouse through the Infrastructure Grant will continue and ultimately improve the collection and reporting of data.

APPENDIX SUMMARY

Appendix I – Map of Collaborative Systems of Care, page 7

The map shows the counties that have Collaborative Systems of Care serving youth and families in Wisconsin. They include the following:

- 2 managed care programs (Children Come First - Dane County and Wraparound Milwaukee), which are funded with a combination of Medicaid and county administered funds.
- A grouping of 6 rural counties, known collectively as the Northwoods Alliance for Children and Families, which is funded by a Center for Mental Health Services' grant and other funds.
- 18 additional counties have Integrated Services Projects that receive mental health block grant funds.
- 10 counties are currently receiving funding (combination of MHBG, Division of Children and Families funding, and Substance Abuse Grant) to implement CST (2 of these counties also receive funding for ISP)
- 6 additional counties are developing CSTs without grant funding aid from the State.

Appendix II – Child & Adolescent Functional Assessment Scale (CAFAS) Results, page 8 - 11

Overview of specific outcomes in overall functioning; functioning at school; and functioning in the community (juvenile justice outcomes) for children involved in ISPs.

Appendix III – 2003 Family Satisfaction Survey Results, page 12 - 15

Families enrolled in ISP & CST initiatives across the state were asked to complete a Family Satisfaction Survey. The purpose was to gather information from a family perspective about areas of strength and need in collaborative systems of care in Wisconsin. To encourage families honest responses, and help ensure confidentiality, the surveys included stamped, addressed envelopes that families could return directly to Wisconsin Family Ties, who tabulated the results.

Appendix IV – Wisconsin Collaborative Systems of Care 2003 System Change Update, page 16 - 23

This report summarizes data gathered from the annual survey sent to ISP and CST sites. Sites were asked to report the actual number of children and families served. They were also asked to comment on the impact of the wraparound process on their system of care and the lives of the families they serve.

Appendix V – Coordinated Services Team Initiative Annual System Change Report 2003, page 24 - 26

The 10 counties receiving funding for the development of CSTs completed the "Goals and Expected Outcomes Checklist" on which they rated themselves in the following three areas: system outcomes supporting CST; process outcomes supporting CST; and family-specific outcomes).

Appendix VI – 2003 Self-Report: Summary of Eight Key Components, page 27 - 30

As a part of their annual report, each of the 19 Integrated Services Projects (ISPs) completed a self-report that asked them to measure how well they met the eight key process and outcome areas that

Douglas
Bayfield
Iron
Ashland
Vilas
Washburn
Burnett
Sawyer
Price
Florence
Oneida
Forest
Marinette
Polk
Barron
Rusk
Lincoln
St. Croix
Dunn
Chippewa
Taylor
Langlade
Menomonee
Oconto
Door
Pierce
Eau Claire
Clark
Marathon
Shawano
Pepin
Wood
Portage
Waupaca
Buffalo
Brown
Kewaunee
Jackson
Outagamie
Trempealeau
Juneau
Waushara
Winnebago
Manitowoc
Monroe
Adams
Calumet
LaCrosse
Marquette
Sheboygan
Green Lake
Fond du Lac
Vernon
Sauk
Ozaukee
Richland
Columbia
Dodge
Washington
Crawford
Waukesha
Dane
Milwaukee
Iowa
Jefferson
Grant
Racine
LaFayette
Green
Rock
Walworth
Kenosha

Developing CSTs = 6

Managed Care = 2

ISPs = 18 (2 are included in [ ] **)**

CSTs = 10 (2 are included in [ ] **)**

ISP and CST = 2 (included in totals for ISPs and CSTs)

Northwoods Alliance = 6

Counties with operational Integrated Services Projects (ISP's) are required to provide outcome data for each child at time of enrollment, and quarterly thereafter to the Bureau of Mental Health and Substance Abuse Services. One of the tools used to collect such data is the Child and Adolescent Functional Assessment Scale (CAFAS).

The CAFAS is a nationally-recognized instrument developed by Dr. Kay Hodges, PhD. used to provide a "behavioral snapshot" of a child's functioning across eight subscales: role performance at **school**, role performance at **home**, role performance in the **community**, **behavior** toward others, **moods & emotions**, **self-harmful behaviors**, **substance use**, and **thinking**. Changes over time in individual subscale scores as well as changes in total scores serve as indicators to teams of where a child has improved and in what areas collaborative planning still needs to occur.

Specific outcomes in overall functioning, functioning at school, functioning in the community (juvenile justice outcomes), and living situation/placement are detailed below. The changes in functioning over time discussed below are considered estimates because the average scores at different intervals do not include the same group of children. Complete data at all intervals through 18 months is not available for enough children to analyze at this time, but will be examined in the future. The exception to this is the data on living situation, which describes living situation at enrollment and discharge for the same group of children.

──────────────── **Improvement in Overall Functioning** ────────────────

Children enrolled in Integrated Services Projects (ISPs) are rated at intake and then quarterly (after the team completes the child's Plan of Care) using the *Child and Adolescent Functional Assessment Scale* (CAFAS).

CAFAS Scoring: Total Score*	
8-Scale Sum	**Description**
0 – 10	*No noteworthy impairment*
20 - 40	*Youth can likely be treated on an outpatient basis*
50 - 90	*Youth may need additional services beyond outpatient care*
100 - 130	*Youth likely needs care which is more intensive than outpatient and/or which includes multiple sources of supportive care*
140+	*Youth likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and the community*

*Taken from "CAFAS Self-Training Manual", Kay Hodges, PhD.

Data collected January 2000 to December 2003 show that *at time of enrollment*, the average CAFAS total score was *117.6,* indicating a need for care more intensive than outpatient and/or necessitating multiple sources of supportive care.

After 18 months of involvement in the collaborative team process, the average CAFAS score was *75.3*, indicating a significant decrease in the amount of care needed to maintain the child in his/her community.

Change in CAFAS Scores Over Time
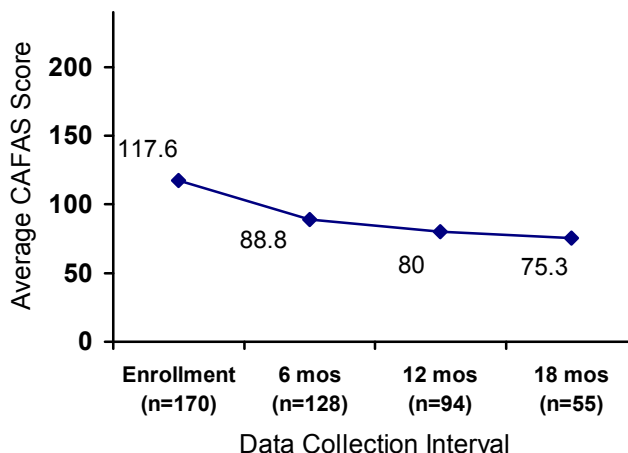
_____ **Educational Outcomes** _____

The **School subscale** of the CAFAS measures school functioning based on academic grades, special education needs, behavior toward other children, and behavior toward teachers and other authority figures in school. Each CAFAS subscale has four rating categories (Severe, Moderate, Mild, and No Impairment). Levels of functional impairment measured by the "Severe" and "Moderate" categories are where providers would hope to see the most improvement. Therefore, the focus of this analysis includes the children who fell into these two categories.

Results of data collected 2000 – 2003 show the percentage of children with "Severe" or "Moderate" functional impairment was 74.7% at enrollment and 52.4% after 6 months of enrollment in the collaborative team process. Perhaps most noteworthy, the percentage of children rated "Severely Impaired" dropped from 49.4% at time of enrollment to 21.9% after 6 months of team involvement.

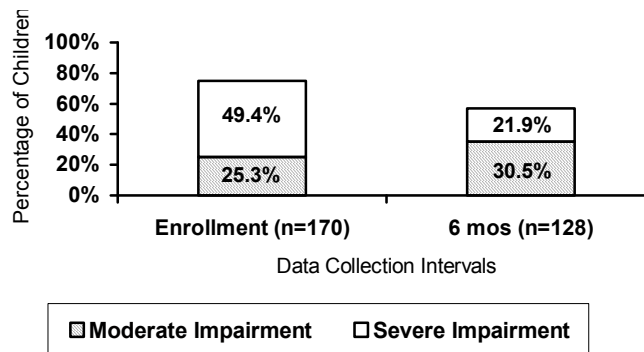> **Characteristics of a "Severe" rating on the School Subscale:**
> Youth is out of regular community school as a result of behavior (e.g. expelled, placed in alternative school setting); or, the youth is displaying behavior that is typically related to removal from school (e.g. dangerous and/or physically aggressive behavior, sexually aggressive behavior).
>
> **Characteristics of a "Moderate" rating on the School Subscale:**
> Youth's behavior results in persistent or repeated disruption of group functioning. Often, the youth is known to others in the school besides the classroom teacher (e.g. vice principal, counselor). Another indicator is that the classroom teacher thinks a special or individualized program is needed (or one has already been implemented).
>
> *Adapted from the CAFAS Self-Training Manual, Kay Hodges, PhD., 2003*

Change in Levels of School Impairment

A bar chart titled "Change in Levels of School Impairment" with y-axis "Percentage of Children" (0% to 100%) and x-axis "Data Collection Intervals". Enrollment (n=170): Moderate Impairment 25.3%, Severe Impairment 49.4%. 6 mos (n=128): Moderate Impairment 30.5%, Severe Impairment 21.9%. Legend: Moderate Impairment, Severe Impairment.

Juvenile Justice Outcomes

The **Community** subscale of the CAFAS measures levels of delinquency based on the frequency, type, and severity of the offense(s). Each CAFAS subscale has four rating categories (Severe, Moderate, Mild, and No Impairment). Levels of functional impairment measured by the "Severe" and "Moderate" categories are where providers would hope to see the most improvement. Therefore, the focus of this analysis includes the children who fell into these two categories.

At time of enrollment, 43.6% were rated as "severely" or "moderately" impaired. After 6 and 12 months of collaborative team involvement, these percentages dropped to 32.0% and 22.3%, respectively.
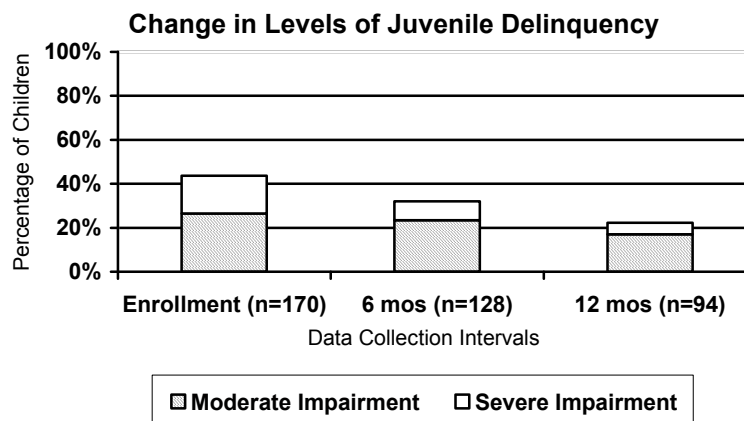
> **Characteristics of a "Severe" rating on the Community Subscale:**
> Youth has been convicted of and/or confined related to behavior which seriously violated the law (e.g. robbery, mugging, fraud, dealing drugs, rape, murder, deliberate fire setting)
>
> **Characteristics of a "Moderate" rating on the Community Subscale:**
> Serious and/or repeated delinquent behavior (e.g. stealing without confronting a victim as in shoplifting, vandalism, defacing property, sexual inappropriateness)
>
> *Adapted from the CAFAS Self-Training Manual, Kay Hodges, PhD.*

A bar chart titled "Change in Levels of Juvenile Delinquency" with y-axis "Percentage of Children" (0% to 100%) and x-axis "Data Collection Intervals" showing Enrollment (n=170), 6 mos (n=128), and 12 mos (n=94). Legend: Moderate Impairment, Severe Impairment.
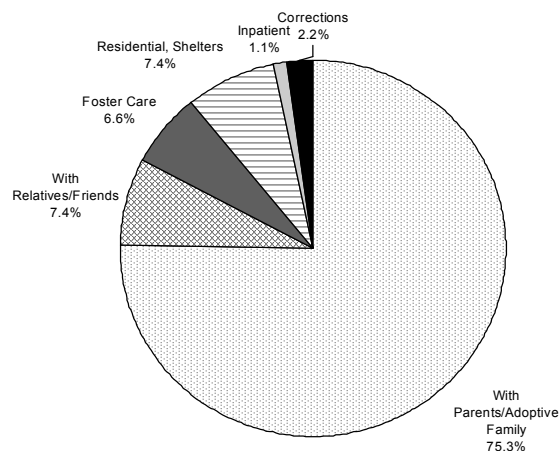
Living Situation Outcomes

Integrated Services Projects (ISP's) strive to reduce restrictive placements and maintain stable placements for children. Most children (73.8%) lived with their biological parent(s) or adoptive parent(s) at time of enrollment in ISP. Similarly, 75.3% of these same children were living with their biological or adoptive parents when discharged. There was also little change from enrollment to discharge in the percentage of children living with relatives/friends or in foster care placements, residential or shelter facilities, inpatient hospitals, or correction settings. The most significant change was the decrease in children in inpatient settings (4.1% to 1.1%). Overall, though, living situations were mostly stable at enrollment, and ISP's were able to maintain this pattern of stable placement at time of discharge.
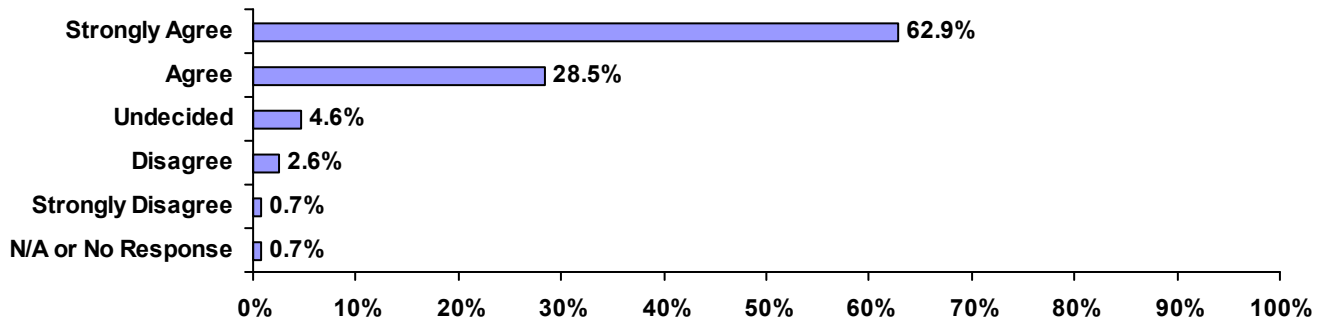
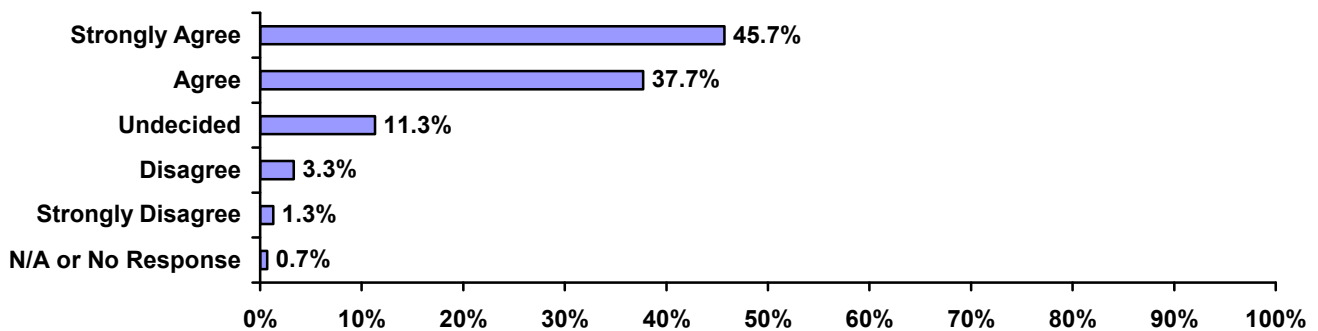### Living Situation at Enrollment (N=271)
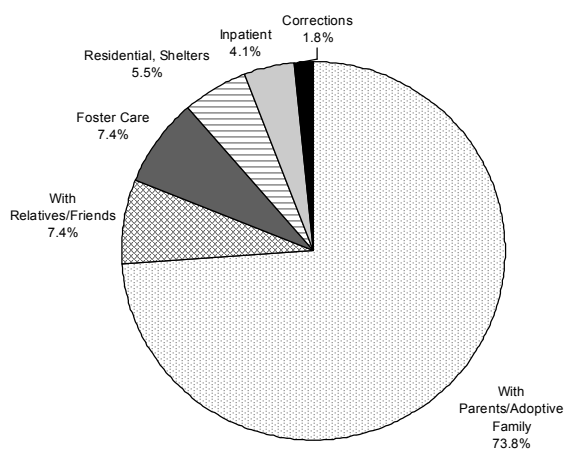
Living Situation at Discharge (N=271)

1. I feel I am treated as an important member of my child and family team.

Strongly Agree	62.9%
Agree	28.5%
Undecided	4.6%
Disagree	2.6%
Strongly Disagree	0.7%
N/A or No Response	0.7%

2. I am satisfied with the goals the team and I have set.

Strongly Agree	45.7%
Agree	37.7%
Undecided	11.3%
Disagree	3.3%
Strongly Disagree	1.3%
N/A or No Response	0.7%

3. The team takes time to listen to my concerns.

Strongly Agree	57.6%
Agree	33.8%
Undecided	6.0%
Disagree	1.3%
Strongly Disagree	0.7%
N/A or No Response	0.6%
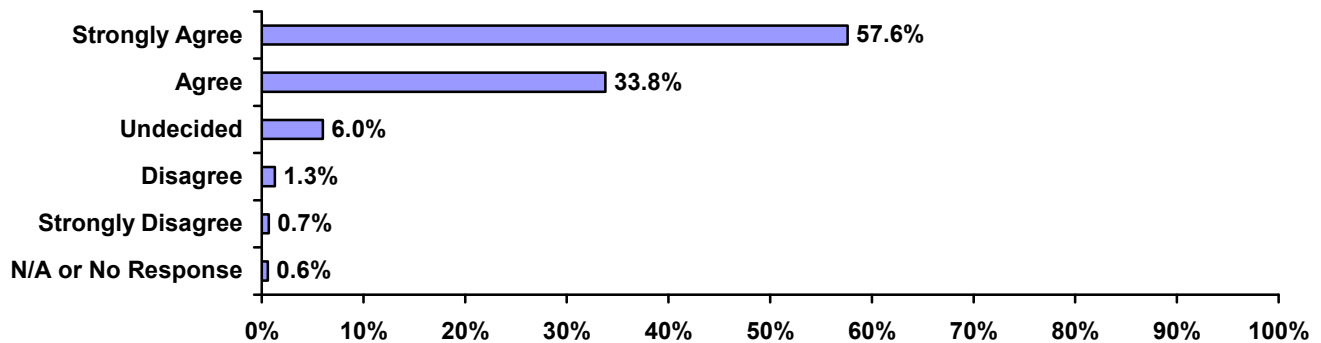
4. My family is getting better at coping with life and its daily challenges.

Response	Percentage
Strongly Agree	21.2%
Agree	45.7%
Undecided	24.5%
Disagree	2.6%
Strongly Disagree	4.0%
N/A or No Response	2.0%
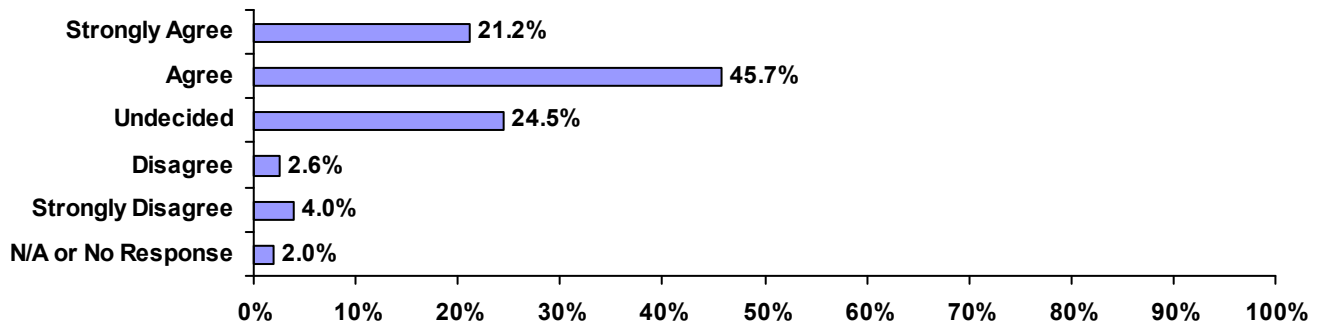
5. I would refer another family/child to the Integrated Services Project.

Response	Percentage
Strongly Agree	60.9%
Agree	29.8%
Undecided	4.0%
Disagree	0.7%
Strongly Disagree	4.0%
N/A or No Response	0.6%
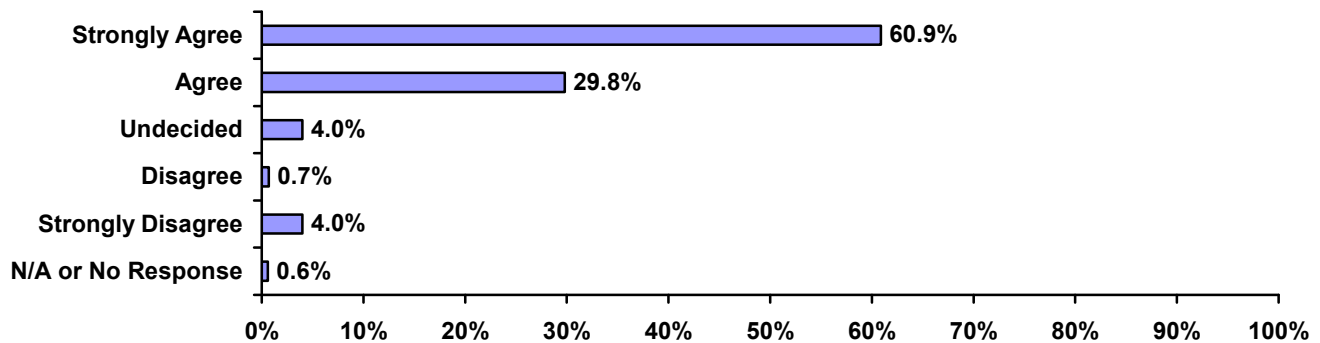
6. My care coordinator speaks up for my child and family.

Response	Percentage
Strongly Agree	51.0%
Agree	34.4%
Undecided	7.9%
Disagree	3.3%
Strongly Disagree	0.7%
N/A or No Response	2.7%
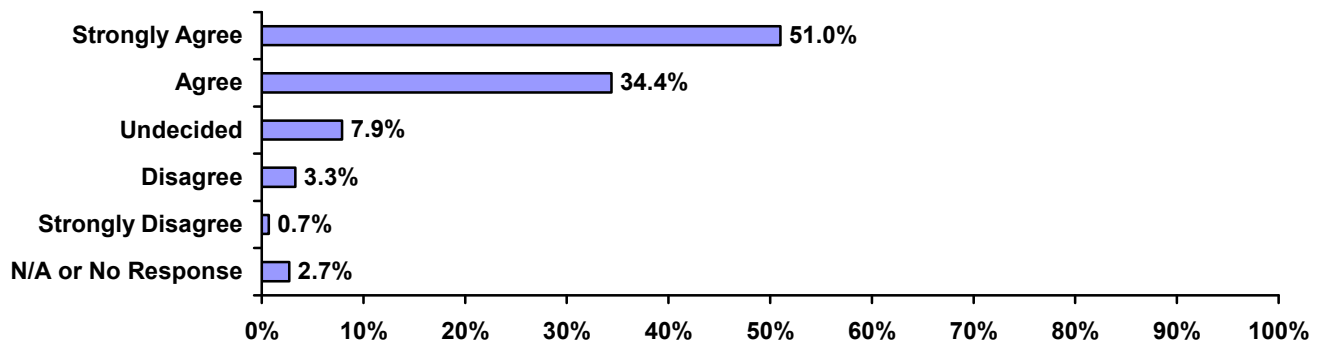
7. The team is sensitive to my cultural/ethnic/religious preferences and values.
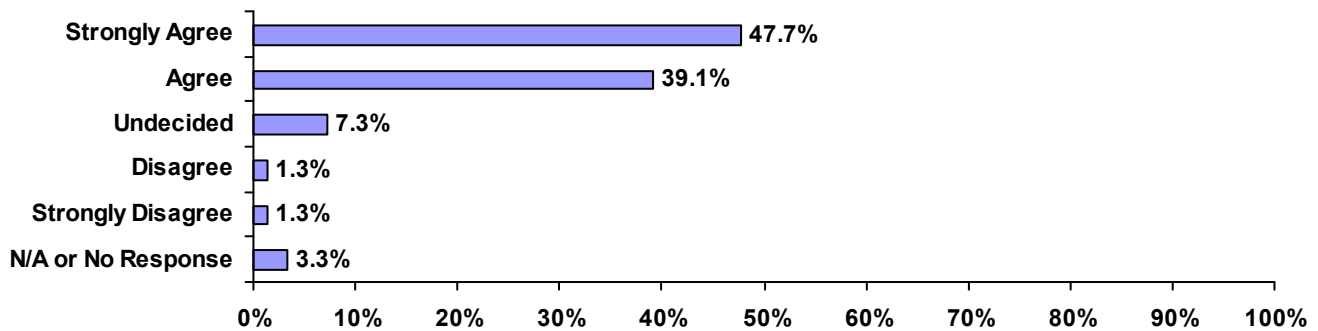
Response	Percentage
Strongly Agree	47.7%
Agree	39.1%
Undecided	7.3%
Disagree	1.3%
Strongly Disagree	1.3%
N/A or No Response	3.3%

8. The team schedules services and meetings at times that are convenient to me and my family.

Response	Percentage
Strongly Agree	62.9%
Agree	31.1%
Undecided	2.6%
Disagree	1.3%
Strongly Disagree	0.7%
N/A or No Response	1.4%

9. If my child is 14 or older, the team has a plan to insure he/she can get neded services when 18.

Response	Percentage
Strongly Agree	4.6%
Agree	11.9%
Undecided	12.6%
Disagree	6.6%
Strongly Disagree	2.6%
N/A or No Response	61.7%
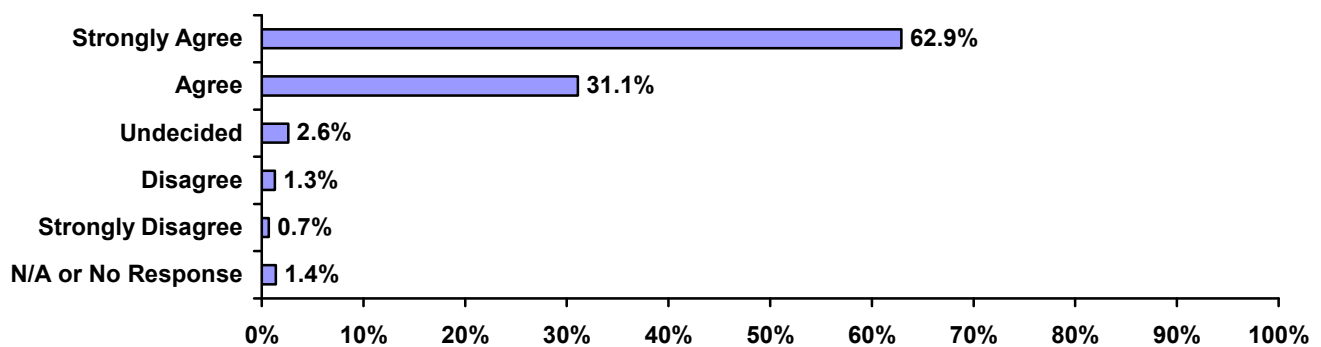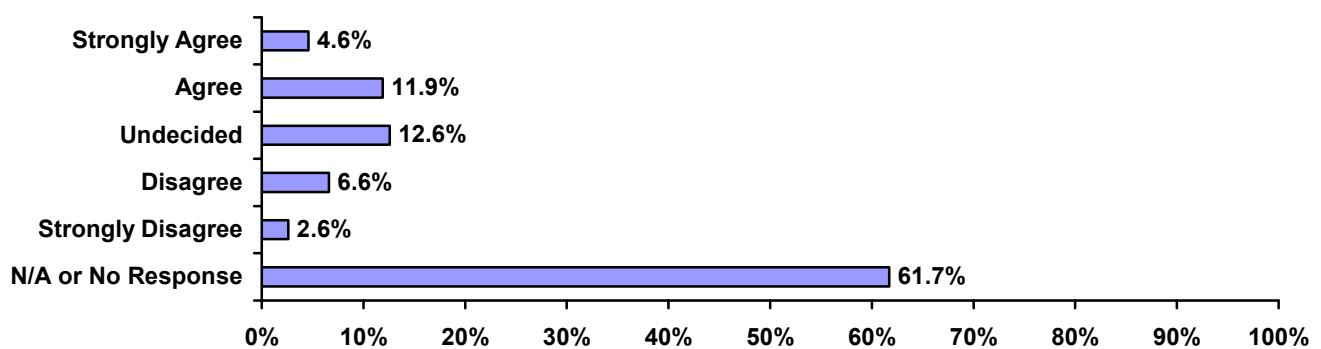
10. I feel the team understands my child's strengths and needs.

Response	Percentage
Strongly Agree	41.1%
Agree	45.0%
Undecided	7.9%
Disagree	4.6%
Strongly Disagree	0.7%
N/A or No Response	0.7%
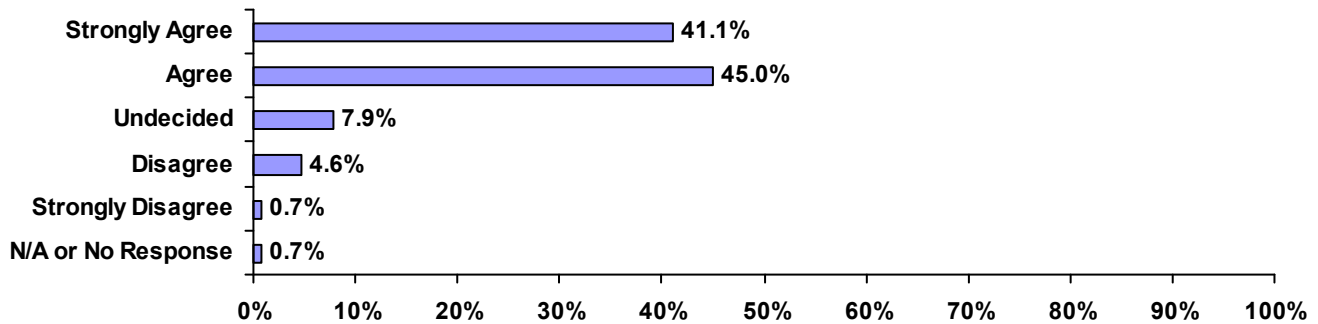
11. I know the team uses my child's strengths in setting goals and making plans.

Response	Percentage
Strongly Agree	40.4%
Agree	45.0%
Undecided	9.9%
Disagree	3.3%
Strongly Disagree	0.7%
N/A or No Response	0.7%
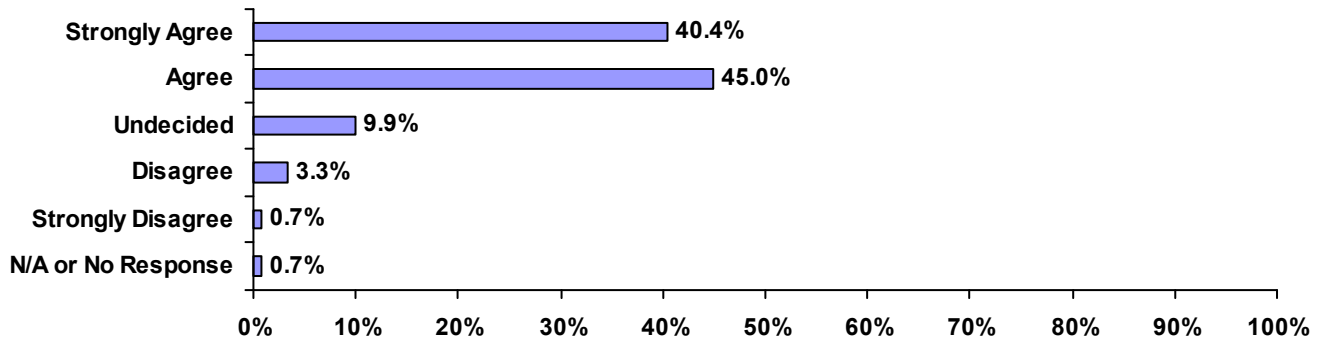
12. Overall, I am satisfied with the efforts of the team on my family's behalf.
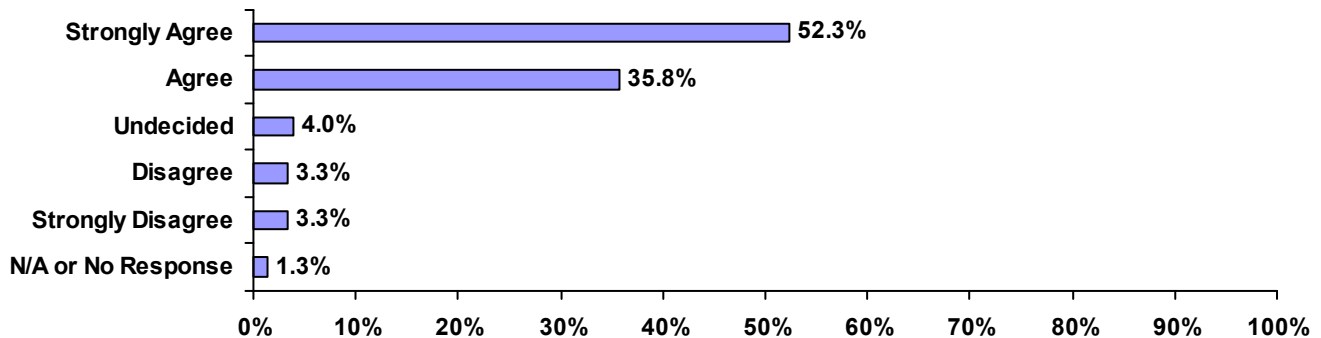
Response	Percentage
Strongly Agree	52.3%
Agree	35.8%
Undecided	4.0%
Disagree	3.3%
Strongly Disagree	3.3%
N/A or No Response	1.3%

Counties with Integrated Services Projects (ISP) and Coordinated Services Team Initiatives (CST) are asked to fill out an annual survey including information on the personnel structure, enrollment information, and "system impact" of their collaborative efforts. The first two sections are quantifiable and data are presented in the charts that follow. The "system impact" section consists of written comments, which are summarized in the final pages of this appendix. Twenty-six counties (16 ISP, 8 CST, and 2 with both programs) returned the survey.

Below is a summary of the data collected, including information on: ISP/CST staff, expressed in FTEs (full-time equivalents); enrollment information; services to other family members; referent information; and length of enrollment.

Staff

> Programs reported a variety of job titles, representing a total of 58.12 FTE, or a little less than 2.5 full-time staff per county. The number of staff ranges between 1.0 FTE in several counties to 6.0 FTE in Kenosha County. About 60% of the positions are service coordinator positions.

Enrollment Information

> ***Total 2003 Enrollment = 750 Youth & Family Teams***
>
> ***Formal Enrollment***
>
> There are a total of 500 formally enrolled youth/family ISP and CST teams in the 26 counties. Thus, the average number of teams per county is 19.2, ranging from 0 in counties just initiating their CST projects (Several CST projects began project development mid 2003) to 109 teams in Kenosha County. The chart below displays the number of formally enrolled teams by size for 2001, 2002, and 2003. Note that 21 counties reported in 2001, 19 in 2002, and 26 in 2003.

Number of Formally Enrolled Teams	Number of Counties	Number of Counties	Number of Counties
	2001	**2002**	**2003**
0 – 19	13	13	21
20 – 39	7	3	1
40 – 59	1	2	3
60 +	0	1	1

> ***Informal Enrollment***
>
> "Informal" teams refer to teams that are served above and beyond the scope of the grant, as grant funds are limited in the number of teams they can support. Counties successful in system change find themselves serving many family teams utilizing resources other than grant funds.
>
> Counties reported a total of 250 informal teams, indicating a 50% increase in total teams served above formally enrolled teams. The number of informal teams ranges from one in several counties to 77 in Waukesha.

Services to Other Family Members

These data capture the number of family members other than the identified youth who receive support and services that they may not have received if the family had not been involved in the collaborative team process. In 2003, there were a total of 1767 additional people served in the counties that reported this number. This compares with a total of 837 additional people served in 2001, and 1363 additional people served in 2002. The number of counties reporting more than 100 additional family members served increased from 0 in 2001 to 5 in 2003.

No. of Family Members Served	Number of Counties	Number of Counties	Number of Counties
	2001	**2002**	**2003**
0 – 19	5	5	6
20 – 39	4	2	4
40 – 59	3	2	4
60 +	5	8	10

Enrollment Summary

ENROLLMENT SUMMARY	2001	2002	2003
Number of formally enrolled teams	402	418	500
Number of informally enrolled teams	264	250	250
Subtotal	666	668	750
Additional family members served	837	1363	1767
Total Served	**1503**	**2031**	**2517**

Source of Referral

Counties were asked to identify the source from which enrolled youth were referred. Options on the survey included: mental health system, child welfare, juvenile justice, AODA, school, and "other." Several counties indicated that the "other" source was "parents and grandparents" (4.5% of the "Other" category).
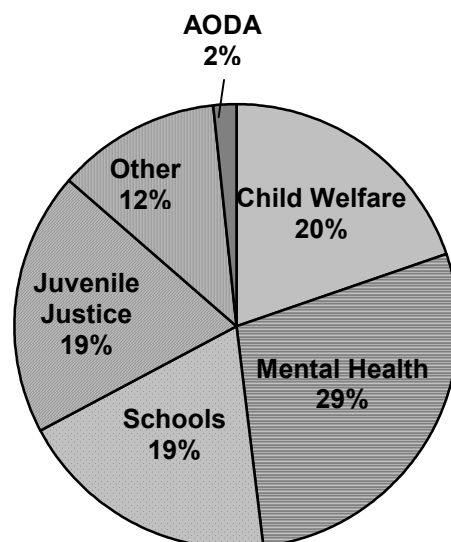
Length of Enrollment

The average length of enrollment in 2003 ranged from 12 months in 3 counties to 42 months in one county. The average length of enrollment per county (not weighted for the differences in enrollment numbers in each county) is 20.0 months, compared to 21.6 months in 2001 and 17.9 in 2002. The length of enrollment numbers were calculated for ISP programs only.

Number of Months	Number of Counties	Number of Counties	Number of Counties
	2001	**2002**	**2003**
Less then 12	0	4	0
12 – 23	11	12	14
24 - 35	6	2	3
36 - 48	0	1	1

Below is a summary of comments and recommendations gathered from the **2003 Collaborative Systems of Care System Change Update:**

How has the collaborative system of care positively or negatively impacted other parts of the child and family service delivery system in your county?

I.   **System of Care Expansion**
*   Our program has increased service coordination for our clients
*   Time is spent discussing how to further promote system change as it relates to continuing to develop the juvenile justice system in Jefferson County to fully utilize the principles of Balanced and Restorative Justice. There is a strong Coordinating Committee that is prepared to advocate for the project and further spread information and involvement throughout the county.
*   We have paved the way with the strength-based wraparound approach. The concept of having family/team meetings has taken off, and everyone is starting to see the benefit of having formal and informal supports being brought together towards one goal.
*   The current ISP has enabled us to expand the concepts to other agencies throughout the county.
*   Multi-system teams and program planning development and implementation in the areas of prevention, intervention and treatment are now occurring in all areas of service to children and their families.

II.   **Collaboration**
*   A much more collegial, collaborative process has developed over time
*   Is has united agencies and departments previously not united
*   Our collaborative partnership continues to expand to new school districts, agencies and organizations.
*   ISP has increased communication between Human Services, schools, and has increased the sharing of service delivery.
*   Systematic barriers are being addressed and broken down.
*   Other systems, especially schools, have become involved with families beyond what has been considered their traditional roles.
*   We have seen an increase in communication with collaborative agencies as plans of care are followed. This includes a more positive working relationship with the school and Behavioral Health Services, resulting in a decrease of emergency detentions and expulsions.

III. **Community-Based Options: Saving Money**
*   (3) The project has helped to continually reduce the number of out of home placements.
*   In the year 2003, only one adolescent was in residential treatment and he as returned to live with his extended family in less than a year.
*   The Child/Family team resulted in child returning from CCI where costs were $7,279.00 per month. Since child is living at home there are no residential costs.
*   Since we have had the Coordinated Services two children have come back to the community with new support networks for themselves and their families. Two other children will be returning to Hurley school in the next two months with a third to follow shortly after. These children would not be returning to the community as soon as they are without support of the CST process.

IV.   **Impact on Families**
*   Parents who have been through the formal Integrated Services process continue to call about referring other families.
*   Plan of care draws on/develops natural supports with in community.
*   Families are especially happy that it is a voluntary program and that they determine the length of involvement.
*   Parents enjoy having the ownership and the decision making power.
*   Children Come First has brought us together as a family.
*   Children with severe emotional disabilities and their families are served better through CCF process, receiving a 4.27 rating out of 5 on a provider survey.
*   Increased advocacy resource has filled a primary role in the service system.

V.   Impact on Juvenile Justice and Child Welfare Systems, including Crisis Intervention

- Crisis Response Plans developed through the team process have had a very positive impact on the system
- Crises have been dealt with quicker, more effectively, and a safer environment.
- Municipal law enforcement stated specific positive impacts: a strengthened relationship with parents and children involved in ISP; and, team membership allows officers to change roles and become more helpful to families.
- Time is spent discussing how to further promote system change as it relates to continuing to develop the juvenile justice system in Jefferson County to fully utilize the principles of Balanced and Restorative Justice. There is a strong Coordinating Committee that is prepared to advocate for the project and further spread information and involvement throughout the county.
- The crisis respite plan is working well for the participants and their families, it has helped keep kids out of alternate care
- A decrease of emergency detentions and expulsions.

VI.   Impact on Schools

- School staff stated a strengthened relationship with ISP students and parents
- Through the ISP/CST process, other systems, especially schools, have become involved with families beyond what has been considered their traditional roles.
- We have seen an increase in communication with collaborative agencies, as plans of care are followed. This includes a more positive working relationship with the school and Behavioral Health Services resulting in a decrease of emergency detentions and expulsions.

VII.   Access to Training/Inservice

- Inservice training: The Children Come First Coordinating Committee conducted a "Children and the Mental Health System: mini conference in April of 2003. The conferences have been extremely successful since it's conception in 2002. Another conference is being planned for October of 2004.
- A spin-off from the mini conference was the development of an evening workshop for childcare providers in August 2003 titled: "The Emotional and Behavioral Development of Young Children." Approximately 120 childcare providers attended the conference.

VIII.   Negative Impacts

- Negative aspects of the ISP include a waiting list and the need to expand the program.

Is support the children and families in your collaborative system of care receive cost effective? Are there cost savings? Please explain.

I. Financial Savings
- Ten (10) comments reflected the general financial savings that comes with diverting costly out-of-home placements while making use of community resources through collaborative family team planning.
- Our program is providing services for each child at a cost of about $25,000 a year, a lot less than the $90,000 institutional rate for a year.
- We continue to estimate a cost savings of $200,000-$400,000 per year from this type of programming which includes intensive in home family therapy.
- The average monthly cost of a child enrolled in our ISP for 2003: $789.77.
- The average monthly cost of a child enrolled in ISP living at home is well below $2,000.00 a month.
- A County savings in that more monies can be spent improving services for all members of the community instead of the few very needy families that have consumed the majority of county resources.
- Significant funding has been diverted from out of home placements to family and community based services. DHHS has been able to commit staff positions to service coordination and fund increased advocacy services.
- The Child/Family team resulted in child returning from CCI where cost were $7,279.00 per month. Since child is living at home there are no residential costs.
- During the first year of operation (August – December 2001), the Project was able to obtain $38,2000 in MA case management. In 2002, $124,000 was received and through September 2003 we have received $94,500 in MA dollars. This money has gone back into the contract to assist in the funding of the case management positions.
- Our current ISP participants cost $45,795 with an estimated cost of out-of-home care of $144,370.
- The Department overall has witnessed a decrease in out of home spending of over $90,000 in 2003. A great deal of this can be attributed to the methodology of the CCF program.

II. Additional Comments
- With shared funding and resources, we are able to provide better service options than one agency could do alone.
- DHHS has been able to commit staff positions to service coordination and fund increased advocacy services.
- Systems savings in reduced need for crisis intervention (social workers, criminal justice systems, school system, economic system - in that parents do not lose work time visiting their children in facilities outside the community.
- Knowledge of families currently being served shows that several children who were hospitalized are now functioning well at home. We see this as being cost effective and a service savings approach. We are also using Wraparound for children in jeopardy of out of home placement, which we anticipate will result in cost savings in this area.
- Increased community cohesion – partners in the process being to understand the overwhelming barriers that have prevented the families in need of receiving the supports and services that provide the glue that holds the family together and integrates them back into the community.
- An overall Community savings in that we promote healthier families who in turn provide more support for every member in the community.
- There are other specific case examples highlighting the cost effectiveness of the above and beyond out of home spending. 2003 saw us removing housing and transportation barriers for a family that had been in the system for far too long, now the family is in their own apartment, has reliable transportation and is no longer reliant on our services.

What concerns, issues, and challenges do you identify?

I. Training & Public Relations
- Training, education related to crisis planning.
- An increasing number of service providers and families know about Integrated Services, only a small percentage really fully understand the process.
- Orientation and training for a 50-team system.
- Values/principles have not yet been fully embraced by the staff.
- Continue to impart the ISP vision to new counties.
- Recruitment, retention and attendance of coordinating committee members.

II. Data Collection & Paperwork
- The amount of reporting required by state is very demanding and time consuming.
- Of course there is always the paperwork that is a challenge.
- The paperwork process has been identified as a concern.

III. Service Provision
- There are never enough funds, causing a scramble to provide services.
- The future fear is the loss of more positions. In the last two years in our Division seven positions have either been eliminated or placed in a freeze mode. This certainly impacts the services we can provide.
- Locating informational supports.
- Increased strength-based support from all factions of providers of services.
- Creative ways to provide respite and childcare to needy families in the community.
- We have an increasing concern for lack of dental care and child psychiatric care for persons on Medical Assistance.

IV. Sustainability
- One of the larger challenges will be to become completely self-sufficient. Creating system wide commitment to this approach.
- Due to budget crisis's the county board's answer is layoffs, I fear more layoffs this year in spite of cost savings.

IV. Working with Families
- Increasing parent involvement at all levels.
- Engaging resistant families in the ISP/CST process.
- Severely emotionally disturbed youngsters and families are being referred to our program
- Issues of confidentiality when using non-formal and formal supports.
- Breaking the barriers to the isolation that so many of our families experience.
- More parent participation on our Coordinating Committee.
- A need for a family network to connect families to each other in the community.
- Many employed families are working part time at minimum wage jobs with no benefits. It becomes very difficult to engage families in ISP in home treatment services when their basic survival needs are not being met.

What recommendations do you make to improve your collaborative process?

II.   **Collaboration & Building Relationships**
- Further community-relations work.
- Strengthen all partnerships.
- Revitalize coordinating committee.
- Increase parent participation on Coordinating Committee.
- Internal marketing of CST and its effectiveness
- Continue to educate the community about the CST process.

III.   **Increased Resources**
- Sufficient resources to develop a second full team of 2 in home therapists and 1 case manager.
- Need a project director to deal with programmatic issues.
- Expand advocacy resources.
- Build more informal supports.
- Access to one-on-one tutoring and mentoring programs.
- Connect parents to each other.
- Use of successfully disenrolled families as both entry and exit resources.

IV.   **Training & Education**
- Offer two-day CAFAS training by Kay Hodges for all project directors.
- More forums for project directors to gather and brainstorm together.
- We are more comfortable handling cases that are not SED but are Juvenile Justice, Child Welfare or AODA connected.
- Continue to do in-service agency staff, the coordinating committee, and the community about the CORE values and guiding principles of the ISP/CST process.
- Engage in and promote more system, partner and family trainings.

V.   **Data Collection/Paperwork Reduction**
- Would like the quarterly reporting system more user friendly.
- Develop a more cohesive, concise, understandable paperwork process.
- Build our data collection process in order to present clear information.

VI.   **Sustainability & Expansion**
- Expand the program so it is available to for all children
- Continue our strategic planning process.
- Expand program to allow for more intensive transitional services.
- Formalize quality assurance system.

VII.   **Special Issues**
- We are confronted with some unique situations to urban areas. Middle school student populations range from 1700 to 22,0000 children. The dynamics of working with a child who goes to school with 1700 other children every day are very different from those working with a child who attends a rural school.
- Approximately 40% of Racine's youth population is minorities. The Hispanic population has more than doubled in the last ten years – increasing the number of parents of young children who do not speak English. Consequently, there is a wide range of cultural values and practices that staff need to understand and respect.

Goals and Expected Outcomes Checklist

Upon receiving Coordinated Services Team Initiative (CST) funding, all counties were asked to complete the "Goals and Expected Outcomes Checklist" (GEOC). The initial completion of this tool serves as a baseline for each county. Counties are asked to evaluate their current system in three areas (system outcomes supporting CST; process outcomes supporting CST; and, family-specific outcomes) by rating themselves on several indicators for each of the three areas. The rating choices are as follows.

> **GEOC Rating Choices:**
> 1 – Ready to begin
> 2 – Planning
> 3 – Initial implementation phase/learning
> 4 – Expanding implementation
> 5 – Fully developed/operational

The six original CST sites (Calumet, Green Lake, Iron, Jefferson, Manitowoc, and Waupaca counties) all completed the GEOC twice: first once upon receiving their grants (January 2003), and again in October 2003. The four counties in the second stream of funding (Bayfield, Marquette, Portage, and Sauk) completed their initial GEOCs in October/November, 2003. Results of counties' initial CEOCs illustrate each County's unique level of need (see table below). In general, the counties with previously established Integrated Services Projects (ISPs) – Waupaca, Jefferson, Calumet, Portage, Sauk, and Marquette – reported a higher average starting point (indicating initiatives expanding implementation to fully operational) than the counties who didn't have ISP/wraparound projects prior to CST. Results of the October GEOCs show all six original sites report they are currently at or exceeding the "initial implementation phase".

Average Total Ratings on "Goals & Expected Outcomes Checklist"
**by County – Jan 2003 and October 2003**
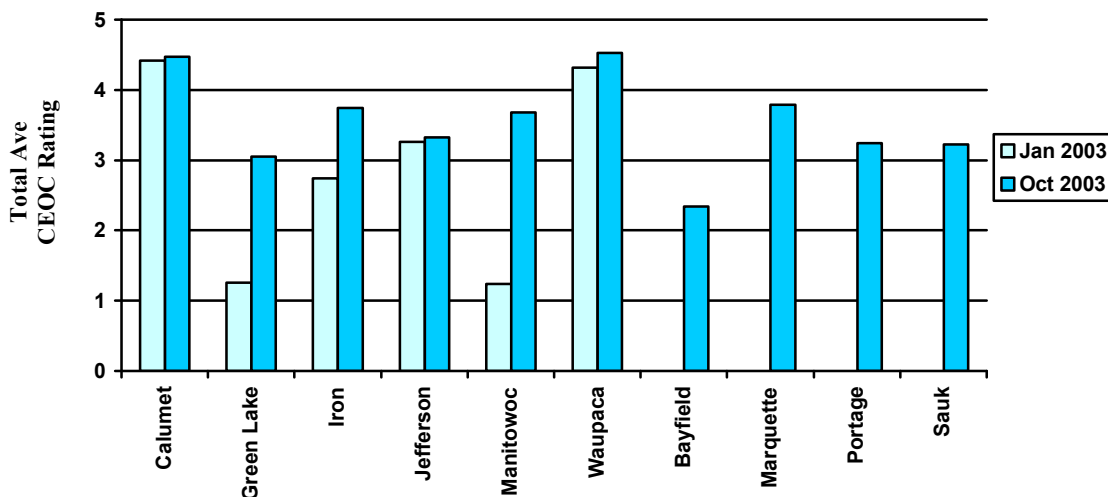
Jefferson and Waupaca Counties, both counties having established ISPs prior to receiving CST funding, rated themselves higher on several indicators on their initial GEOCs than on their 2nd CEOCs, indicating increased expectations and a desire to improve upon existing systems to accommodate their projects' expansions to CST.

When considering the three broad areas counties were asked to rate themselves on: System Outcomes Supporting CST; Process Outcomes Supporting CST; and Family-Specific Outcomes Supporting CST; we can see general areas of strength and need across counties.

Average Total Ratings on For "System Outcomes" Indicators
Jan 2003 and October 2003
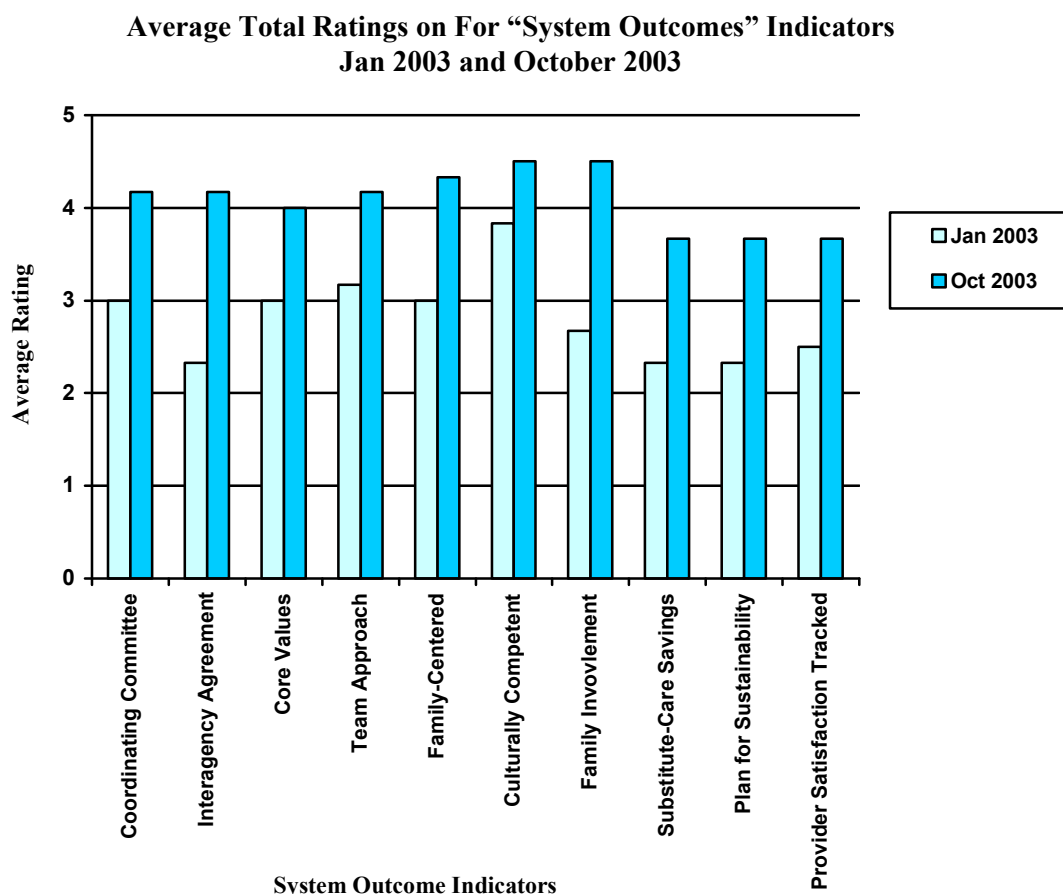
"Family involvement on Coordinating Committees and family teams" is an area strength among the sites. Culturally competent, strength-based, and family-centered services are also areas of strength. Areas reported consistently lower by sites, indicating areas needing additional technical assistance, include: a reinvestment of realized savings from substitute care budgets in community-based CST processes; planning for future sustainability; and provider satisfaction in the process.

Average Total Ratings on For "Process Outcomes" Indicators
Jan 2003 and October 2003
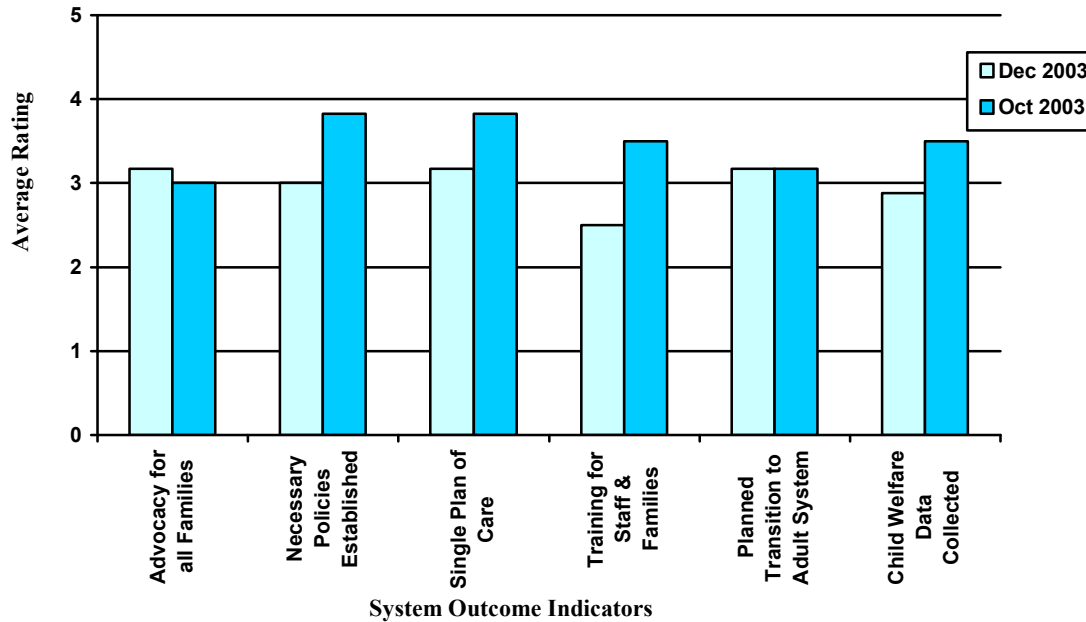
Of the three broad areas counties were asked to rate themselves on (System Outcomes Supporting CST; Process Outcomes Supporting CST; and Family-Specific Outcomes Supporting CST), the "Process Outcomes" area was rated lowest by the sites, indicating a need for continued attention and technical assistance. Specifically, Counties rated "Advocacy is assured for all families" and "Adolescents are ensured a planned transition to adult life" as areas of need.

Average Total Ratings on For "Family-Specific Outcomes" Indicators
Jan 2003 and October 2003
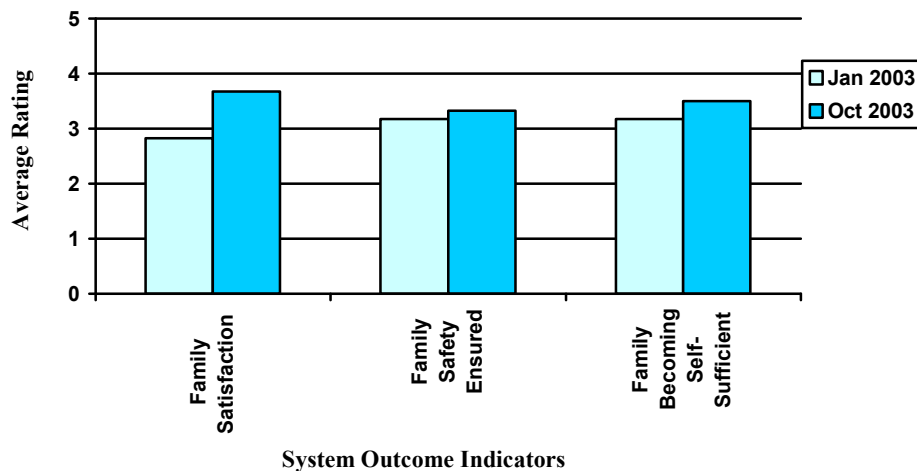
"Family-Specific Outcomes" were rated as areas of strength in Calumet & Waupaca Counties (5.00 and 4.67, respectively). The remaining counties scored "3" or below, indicating a greater need for technical assistance.

I. Parents* Are Involved as Full Partners at Every Level of Activity (*The term "parent" represents all caregivers)

Team Participation

Indicators	Please circle the response that best describes your process			
	4 – Always,	3 – Often,	2 – Seldom,	1 - Never
	Comments			
1. Parents may request meetings.	90%	5%	5%	0%
2. Parents are present @ team meetings. Children are present whenever possible and appropriate.	79%	21%	0%	0%
3. Parents' needs are considered in scheduling meetings.	100%	0%	0 %	0%
4. Parents are involved in selection of team members.	85%	10%	5%	0%

Coordinating Committee Participation

1. Parents on Coordinating Committee and appropriate subcommittees	100% - yes			
2. Parents attend at least 75% of scheduled meetings.	64%	26%	10%	0%
3. Parents feel they are listened to by other committee members and that they have an important role on the committee.	53%	42%	5%	0%

II. An Inclusive Interagency Group (Coordinating Committee) Serving Children and Families Has Agreed Upon the Core Values and Guiding Principles Which Are in the Interagency Agreement

Indicators	Please circle the response that best describes your process			
	4 – Always,	3 – Often,	2 – Seldom,	1 - Never
	Comments			
1. Agreement incorporates all the members and components listed under State Statute 46.56 (3) (5).	94% - yes		6% - no	
2. The Coordinating Committee reviews interagency agreements at least every three years.	83% - yes		17% - no	
3. Coordinating Committee meets at least quarterly.	100% - yes			
4. Conflict resolution policies are clearly written and reviewed at least annually.	82% - yes		18% - no	
5. Conflict resolution policies are followed when disagreements arise.	94% - yes		6% - no	
6. The Coordinating Committee assures that the core values and guiding principles are evident in the operation of the integrated services system of care.	66%	34%	0%	0%
7. Collaborating agencies are satisfied with process.	59%	35%	6%	0%

III. Collaborative Family Teams Create and Implement Individualized Support and Service Plans of Care for Families				
Indicators	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Comments**			
1. Orientation is provided to all team members.	94% - yes			6% - no
2. Team facilitator and/or service coordinator receive training and support.	84%	16%	0%	0%
3. Collaborative family team includes membership from home, school & community.	68%	32%	0%	0%
4. Team composition is consistent with family culture and preferences.	84%	16%	0%	0%
5. Family is satisfied with its team.	42%	58%	0%	0%
6. Family is satisfied with the team process.	32%	63%	5%	0%
7. Process is a collaborative team effort that begins with an individualized strengths- and needs-based assessment.	63%	37%	0%	0%
8. Plan of care flows from assessment.	63%	37%	0%	0%
9. Plan of care incorporates strengths of child, family and team.	79%	21%	0%	0%
10. The plan of care includes specific actions to meet identified needs, including who is responsible (including parents) for completing the action, and the plan is being followed.	78%	22%	0%	0%
11. Family and other team members sign Care Plan.	94% - yes			6% - no
12. Transition is addressed for major life changes.	50%	50%	0%	0%

IV. Significant Collaborative Funding is Available to Meet the Financial Needs Identified in the Plan of Care				
Indicators	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Comments**			
1. Agencies contribute resources and funding to meet the needs of families.	56%	39%	5%	0%
2. Child and family teams use funding flexibly to support individualized service.	50%	44%	6%	0%
3. Child and family team accesses informal community resources.	39%	50%	11%	0%

V. Advocacy Is Provided For Each Family	
Indicators	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Comments**
1. Family advocacy information and options are provided.	100% - yes
2. Advocates may participate as team members as requested by the family.	100% - yes
3. Service Coordinators advocate for families	89% 11% 0% 0%

VI. Ongoing Training is provided to all Participants	
Indicators	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Comments**
1. Coordinating Committee and Project Coordinator identify training needs on an ongoing basis.	88% - yes 12% - no
2. Annual local training opportunities are made available to families, staff, and all others involved with the ISP process.	94% - yes 6% - no

VII.	Functional Goals are Monitored and Measured, Emphasizing Participant Satisfaction				
Indicators	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Comments**				

1.   Generally, outcomes show:
   a. A decrease in police contact/recidivism rates.
   b. Maintenance or decrease in level of restrictiveness of living situation
   c. Improvement in grades
   d. Improvement in attendance.
   e. Decrease in problem behaviors.
	100% - yes
	
	100% - yes
	
	100% - yes
	100% - yes
	100% - yes				

2. Plan reviews are held at least every six months.	94% - yes			6% - no	
3. Family is satisfied with process.	42%	58%	0%	0%	
4. Family is satisfied with outcomes.	32%	63%	5%	0%	
5. Providers are satisfied with process.	47%	53%	0%	0%	
6. Providers are satisfied with outcomes.	41%	59%	0%	0%	

VIII.	Adolescents Are Ensured a Planned Transition to Adult Life				
Indicators	Please circle the response that best describes your process 4 – Always, 3 – Often, 2 – Seldom, 1 - Never **Comments**				
1. A mechanism is in place to identify children age 14 and older who have long-term treatment needs and who will require services beyond age 18.	94% - yes			6% - no	
2. Plans of care reflect collaborative transitional planning for children age 14 and older identified as needing services beyond age 18.	94% - yes			6% - no	

3.   For the most seriously ill adolescents, within one year of transition to adult living:
   a. Action steps are clearly defined,
   b. Needed referrals have been made
   c. Future collaborators are invited to team meetings.
	65%
	76%
	69%
		29%
		24%
		31%
			6%
			0%
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